A Bright-line Rule for the Reasonable Value of Medical Services

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ABSTRACT

Despite their best efforts, Pennsylvania courts have struggled to articulate a workable standard for fixing the reasonable value of medical services. This has profound implications for breach of implied-in-fact contract and unjust enrichment actions related to medical services as both center on the reasonable value of said services. The reasonableness standards that do exist typically ask what services are "ordinarily worth in the community," but the courts offer no guidance on how to discern this "ordinary worth." Moreover, there is no agreed upon interpretation of the meaning of, or the boundaries associated with, the concept of "community." Instead, the courts must engage in an agonized, case-by-case analysis of reasonable value. A bright-line rule would be helpful. Fortunately, Pennsylvania law already recognizes such a rule in the unjust enrichment context, but the rule's applicability to breaches of implied-in-fact contract is unclear. This Article contends that the reasonable value of medical services in all cases should be the average reimbursement rate healthcare providers accept from third-party payors for the services rendered.

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I. INTRODUCTION

The curse of the law is having to build on someone else's foundation. The mistakes of earlier generations assert themselves through later additions until one is left with an architectural atrocity. Sometimes only a wrecking ball can rectify those initial errors—if errors they be. Case in point: there exists in Pennsylvania some confusion regarding the interplay of unjust enrichment and quantum meruit. Courts bear a good deal of the blame as they consistently, and incorrectly, conflate the two concepts.[1] To be clear, quantum meruit is an equitable *remedy* for the breach of an implied-in-fact contract, and unjust enrichment is an equitable *cause of action* remedied by restitution.[2] Courts tend to apply the appropriate measure of damages to the correct cause of action,[3] but opinions continue to use the concepts interchangeably—probably because they are both rooted in equity, employ similar standards, and, as explored later in this Article, quantum meruit bears on unjust enrichment claims, but not the other way around.[4]

In any event, this history of lexical misuse is an inescapable, but largely benign, feature of the law. The real difficulty lies in the fact that quantum meruit is internally inconsistent, especially when it comes to medical services. Over the past century, Pennsylvania courts have failed to devise a bright-line rule for determining the quantum meruit (i.e., reasonable value)[5] of medical services. On one hand, there is precedent that holds that the reasonable value of medical services is "what they are ordinarily worth in the community," but this precedent fails to specify how to determine the parameters of the relevant community.[6] On the other hand, there is precedent that discards the community-based reasonableness standard in certain situations in favor of a "broader pricing concept . . . moving toward a more uniform regional or national standard."[7] But this approach likewise evades the nitty-gritty of how to chart the relevant region. Worse, both the community- and regional-based reasonableness standards are silent on what criteria should be considered when

1. Artisan Builders, Inc. v. Jang, 271 A.3d 889, 892 n.4 (Pa. Super. Ct. 2022); *accord* Bennett v. Artus, 20 P.3d 560, 563 n.3 (Alaska 2001) ("Courts generally treat actions brought upon theories of unjust enrichment, quasi-contract, contracts implied in law, and *quantum meruit* as essentially the same. In fact, this terminology is generally employed interchangeably, often within the same opinion." (internal quotation marks omitted)).
2. *See Artisan*, 271 A.3d at 892.
3. *See id.* at 896 (Bowes, J., concurring).
4. *See id.* at 892–93.
5. *Id.* at 892.
6. Husik v. Lever, 95 Pa. Super. 258, 260 (1929) (en banc).
7. Eagle v. Snyder, 604 A.2d 253, 255–56 (Pa. Super. Ct. 1992).

determining medical services' reasonable value. Thus, any attempt to ascertain the reasonable value of medical services in Pennsylvania is something of a wild goose chase. A workable, bright-line rule is needed, one suited for myriad scenarios across the Commonwealth.

Funnily enough, it was an unjust enrichment case that elucidated just such a rule and, in doing so, resolved many of the underlying policy concerns that prompted courts to expound the earlier, confusing reasonableness standards.[8] This third way maintains that the reasonable value of medical services is the average contracted-for reimbursement rate the provider receives from insurers for those services.[9] This Article argues Pennsylvania courts should adhere to this alternative standard because, among other things, it is principled, eliminates vague geographic considerations rooted in the concept of "community," and ensures real market forces dictate the reasonable value of medical services.[10]

This Article proceeds in five parts. Part II provides a brief overview of the doctrinal framework for contracts and unjust enrichment—with emphasis on the remedy of quantum meruit. Part III explores the leading contract cases in Pennsylvania for determining the reasonable value of medical services, while Part IV discusses the leading unjust enrichment case on the same issue. Part V analyzes the competing reasonableness standards, and Part VI concludes this Article.

II. UNJUST ENRICHMENT VS. "REAL" CONTRACTS

Broadly speaking, the law recognizes three types of contracts: express, implied-in-fact, and implied-in-law—i.e., quasi-contract.[11] This triptych exists in the medical services context.[12] However, not all contracts are created equal. "[W]hile both express and implied-in-fact contracts are real contracts, a quasi[-]contract is not a real contract. That is, both express and implied-in-fact contracts require mutual assent between the contracting parties. A quasi[-]contract lacks mutual assent, and thus it is not a contract."[13] The primary difference between an express contract and an implied-in-fact contract is the manner in which the parties manifest their assent. In an express contract, the parties assent to the contractual

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8. *See* Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc., 832 A.2d 501, 510 (Pa. Super. Ct. 2003) (holding that the reasonable value of medical services is the amount paid by the "community"—*i.e.*, the "average charge" for services based on "contracts with governmental agencies and insurance companies").

9. *Id.*

10. *See infra* Part V.

11. *See, e.g.*, Lach v. Fleth, 64 A.2d 821, 826 (Pa. 1949).

12. George A. Nation III, *Contracting for Healthcare: Price Terms in Hospital Admission Agreements*, 124 DICK. L. REV. 91, 99–100 (2019) [hereinafter *Healthcare*].

13. *Id.* at 121 (footnotes omitted); *accord* Schott v. Westinghouse Elec. Corp., 259 A.2d 443, 449 (Pa. 1969).

terms by means of words, writings, or some other mode of expression.[14] In an implied-in-fact contract, the conduct of the parties and the surrounding circumstances reveal mutual assent to the contractual terms.[15] Lacking mutual assent, a "quasi-contract" is, therefore, something of a "misnomer."[16]

Closer to tort law than contract law, but distinct from both,[17] a quasi-contract is a contract only by way of analogy or metaphor. In quasi-contract, the law "imposes a duty, not as a result of any agreement, whether express or implied, but in spite of the absence of an agreement, when one party receives unjust enrichment at the expense of another."[18] In other words, quasi-contract, or unjust enrichment, is "the retention of a benefit conferred by another, without offering compensation, in circumstances where compensation is reasonably expected, and for which the beneficiary must make restitution."[19] "The most significant element of the doctrine is whether the enrichment of the defendant is *unjust*; the doctrine does not apply simply because the defendant may have benefited as a result of the actions of the plaintiff."[20] Thus, unjust enrichment is no contract at all.[21]

With the above taxonomy in mind, one can see how application of unjust enrichment to express or implied-in-fact contracts would undermine the sanctity of contract with respect to medical services as well as in other contexts.[22] Where the parties have *expressly* contracted for medical services, and that contract contains an explicit price term, the contracted-for price controls.[23] For example, most, if not all, hospital patients sign some kind of admission agreement, and these agreements usually contain

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14. *E.g.*, *In re* Estate of Breyer, 379 A.2d 1305, 1309 (Pa. 1977).

15. *E.g.*, Ingrassia Const. Co., Inc. v. Walsh, 486 A.2d 478, 483 (Pa. Super. Ct. 1984).

16. Nation, *Healthcare*, *supra* note 12, at 121.

17. *See, e.g.*, RESTATEMENT (FIRST) OF RESTITUTION § 5 cmt. a (AM. L. INST. 1937).

18. AmeriPro Search, Inc. v. Fleming Steel Co., 787 A.2d 988, 991 (Pa. Super. Ct. 2001).

19. Roethlein v. Portnoff Law Assocs., Ltd., 82 A.3d 816, 825 n.8 (Pa. 2013) (citing Am. & Foreign Ins. Co. v. Jerry's Sport Ctr., Inc., 2 A.3d 526, 532 n.7 (Pa. 2010)); *see also* Artisan Builders, Inc. v. Jang, 271 A.3d 889, 892 (Pa. Super. Ct. 2022) (stating the three elements of unjust enrichment are "(1) benefits conferred on defendant by plaintiff; (2) appreciation of such benefits by defendant; and (3) acceptance and retention of such benefits under such circumstances that it would be inequitable for defendant to retain the benefit without payment of value").

20. *AmeriPro Search, Inc.*, 787 A.2d at 991 (emphasis added).

21. *Roethlein*, 82 A.3d at 825 n.8.

22. *See, e.g.*, Twp. of Horsham v. Weiner, 255 A.2d 126, 130–31 (Pa. 1969) (holding the parties' express contract "precluded any subsequent assertion of the right to additional compensation on [a quasi-contract] theory").

23. *See, e.g.*, Lach v. Fleth, 64 A.2d 821, 825 (Pa. 1949).

"an open-ended obligation . . . to pay the hospital's 'full charges' (or similar language) for all services and goods provided."[24]

Similarly, where a medical services contract can be inferred from the parties' conduct, the patient receives and accepts those services, but the parties fail to specify the amount of compensation, the law generally *implies* an agreement to pay for medical services.[25] That is, unless the services were intended to be, and accepted as, a gift or act of charity.[26] The law fills the price term gap in an implied-in-fact contract by invoking quantum meruit.[27] "Quantum meruit is an equitable remedy, which . . . measures compensation under an implied[-in-fact] contract to pay compensation as reasonable value of services rendered."[28]

Therefore, if the parties either expressly or impliedly contract for medical services, there can be no claim of unjust enrichment against either the provider or the patient.[29] The provider is entitled to receive, and the patient is obliged to pay, the expressly contracted-for price or the reasonable value of the medical services, respectively. Compelling the provider to disgorge a portion of the amount it was entitled to receive, or the patient to pay more than the agreed upon price or the services' reasonable value? Now *that* would be unjust! It would require courts to "substitute their ex post judgment for the parties' ex ante agreement."[30] Of course, all this assumes the contract's enforceability.[31]

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24. George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101, 117 (2005) [hereinafter *Obscene Contracts*].

25. *E.g.*, *In re* McKeehan's Estate, 57 A.2d 907, 909 (Pa. 1948).

26. *E.g.*, *id.*

27. *E.g.*, *id.*

28. Angino & Rovner v. Jeffrey R. Lessin & Assocs., 131 A.3d 502, 508 (Pa. Super. Ct. 2016).

29. *See, e.g.*, Third Nat'l Bank & Tr. Co. of Scranton v. Lehigh Val. Coal Co., 44 A.2d 571, 574 (Pa. 1945) (stating unjust enrichment "is not applicable to agreements deliberately entered into by the parties however harsh the provisions of such contracts may seem in the light of subsequent happenings").

30. Nation, *Obscene Contracts*, *supra* note 24, at 108.

31. The enforceability of most medical service contracts (express and implied-in-fact) is suspect because "sufficiently definite" terms are an essential element of a binding contract. *In re* Estate of Hall, 731 A.2d 617, 621 (Pa. Super. Ct. 1999); *see also* Lackner v. Glosser, 892 A.2d 21, 31 (Pa. Super. Ct. 2006) (stating that, where there is no agreement or discussion of essential terms like price, "the 'agreement' is too indefinite for a party to reasonably believe that it could be enforceable in an action at law"). In the case of non-emergency admissions, including voluntary inpatient and outpatient treatment, patients and providers often have no way of knowing with absolute certainty the full extent of the medical services a patient will need or the total price the hospital will charge for these services. Most "[p]atients are simply following their physician's advice when seeking medical care from a hospital. In many cases, a patient literally entrusts his life to his doctor's judgment. . . . Typically patients agree to an open-ended obligation . . . to pay the hospital's 'full charges' . . . ." Nation, *Obscene Contracts*, *supra* note 24, at 116–17 (footnote omitted). It is difficult to imagine such scenarios satisfying the definiteness

Conversely, unjust enrichment operates in a contractual vacuum and entails restitution of a portion of the gain received by the defendant at the plaintiff's expense.[32] "The damages analysis is based on principles of *equity*, not contract."[33] Yet courts may resort to contract principles like quantum meruit to help determine the amount of restitution.[34] This is only logical. Every claim of unjust enrichment entails comparison. Enrichment is unjust only when measured against *just* enrichment, and quantum meruit "is the usual measurement of [just] enrichment in cases where nonreturnable benefits have been furnished . . . , but where the parties made no enforceable agreement as to price."[35] Thus, quantum meruit provides the just comparison amount against which to measure the defendant's ill-gotten gains. But quantum meruit is not a monolith; it comes in several flavors.

III. THE QUANTUM MERUIT CONFUSION

While quantum meruit aids in measuring unjust enrichment, the remedy, at least in Pennsylvania, lacks uniformity and predictability when applied to medical services. This is not too surprising. After all, "it is an observation, as true as it is trite, that there is nothing men differ so readily about as the payment of money."[36] Consequently, this Part explores the two main tests in Pennsylvania for establishing the quantum meruit or

requirement of the common law. However, indefiniteness is slightly more understandable in the emergency services context given the impromptu nature of things. Indeed, emergency department admissions present additional hurdles to contract formation—e.g., lack of capacity or inability to assent. *See, e.g.*, St. John's Episcopal Hosp. v. McAdoo, 405 N.Y.S.2d 935, 937 (N.Y. Civ. Ct. 1978). But assuming the terms are definite, other considerations could void contracts between providers and patients. Consider the practice of balance-billing "whereby a provider bills the patient directly for the balance of the . . . charges if the [insurer] does not pay the full amount . . . ." Nickel v. Workers' Comp. Appeal Bd. (Agway Agronomy), 959 A.2d 498, 504 n.10 (Pa. Commw. Ct. 2008). Given the absurdly high charge master rates providers balance-bill patients coupled with the gross disparity in bargaining power between providers and patients (i.e., an essentially "take it, or leave it" proposition in many cases), the doctrine of unconscionability is a promising avenue of contract avoidance. *See* Nation, *Obscene Contracts*, *supra* note 24, at 131–136; *accord* Salley v. Option One Mortg. Corp., 925 A.2d 115, 119 (Pa. 2007) ("[A] contract or term is unconscionable, and therefore avoidable, where there was a lack of meaningful choice in the acceptance of the challenged provision and the provision unreasonably favors the party asserting it."). Alas, a full investigation of these issues exceeds the scope of this Article.

32. *See, e.g.*, AmeriPro Search, Inc. v. Fleming Steel Co., 787 A.2d 988, 991 (Pa. Super. Ct. 2001).

33. Aladdin Elec. Assocs. v. Old Orchard Beach, 645 A.2d 1142, 1145 (Me. 1994).

34. *See, e.g.*, Candace Saari Kovacic-Fleischer, *Quantum Meruit and the Restatement (Third) of Restitution and Unjust Enrichment*, 27 REV. LITIG. 127, 131 (2007).

35. RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 49 cmt. f.

36. THE FEDERALIST NO. 7, at 59 (Clinton Rossiter ed., 1961) (Alexander Hamilton).

reasonable value of medical services: the community- and regional-based standards.

A. Husik v. Lever*: Community-based Standard*

Like King Pellinore's pursuit of the Questing Beast, determining the reasonable value of medical services in Pennsylvania has proven easier said than done. Nearly a century ago, the Pennsylvania Superior Court announced the following standard in *Husik v. Lever*:

> In the absence of an express agreement as to amount, the law implies a promise to pay for a physician's services as much as they are reasonably worth. *Professional services are worth what they are rated at on the professional market*. The physician has his services to sell, *the patient agrees to buy them and pay for them the customary price* . . . . Even when the agreement is completely the creation of the law[,] *the implied promise is to pay for the services what they are ordinarily worth in the community*.[37]

Thus, the implied promise to pay for medical services is the fulfillment of a financial obligation, but the environment in which services are rendered limns the scope of that obligation.

B. Complications for the Community-based Standard

Husik's community-based reasonableness standard—later adopted by the Pennsylvania Supreme Court[38]—appears broad and fluid enough to ensure providers are reasonably compensated for their services in myriad scenarios throughout the Commonwealth. But the *Husik* standard fails to account for a separate legal rule that complicates the reasonable worth calculation. Specifically, the same year *Husik* was decided, the Pennsylvania Supreme Court in *Pfeiffer v. Dyer* held that healthcare providers, like other professionals, have wide latitude when charging for their services.[39] The court explained:

> [P]hysicians should not have their services valued, as you would commodities in trade, by a fixed standard; what would be a proper charge for the same service to a man fully able to pay would be excessive to a man of limited means, and what would be willingly done for the indigent, without thought of financial reward, should be compensated for by one who can afford to pay on the scale which doctors of repute measure as the proper one . . . . It is a matter of common information that physicians and surgeons do not regulate

37. Husik v. Lever, 95 Pa. Super. 258, 260 (1929) (en banc).
38. *See In re* McKeehan's Estate, 57 A.2d 907, 909 (Pa. 1948).
39. Pfeiffer v. Dyer, 145 A. 284, 285 (Pa. 1929).

> their charges by any fixed standard of pecuniary value, but, to a certain extent, base them on the ability of the patient to pay . . . .[40]

Pfeiffer's emphasis on pricing flexibility—and the attendant lack of "any fixed standard of pecuniary value"—runs counter to *Husik*, which strongly suggests the reasonable value of medical services *is* ascertainable. If *Pfeiffer* is correct and every charge for medical services is unique, the whole idea of a "customary" price disappears.[41] The exception becomes the rule.

But the courts' deference to the medical profession's price-setting has its limits. As the Pennsylvania Supreme Court explained in a later case: "[W]hile the opinion of other physicians is competent on the question of the value of a doctor's services, it is not so conclusive as to take the place of the judgment of the [factfinder] whose duty it is to pass on the question of the value of the services."[42] In non-jury proceedings, appellate courts review this judgment for abuse of discretion.[43] Thus, the factfinder may determine for itself the customary charge for services, even if *Pfeiffer* indicates no such charge can or should exist. But one more legal fiction can't hurt.

C. Eagle v. Snyder*: Regional-based Standard*

Husik's community-based reasonableness standard employs rather windy language, a vestige of a less mature jurisprudence. With a standard so imprecise, lower courts will invariably struggle to determine what words and phrases like "reasonable worth," "professional market," "customary price," and "community" mean. A list of facts and circumstances to consider when assessing the reasonable value of medical services would have been nice, but *Husik* offers only a skeletal framework. Flesh sold separately—if at all. And *Pfeiffer*'s approval of ad hoc pricing compounds *Husik*'s ambiguities. Even so, *Husik* remained inviolate for decades until the community-based standard was revisited in *Eagle v. Snyder*.[44]

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40. *Id.* (citation and internal quotation marks omitted).

41. *See Customary*, DICTIONARY.COM, https://perma.cc/S6AN-AHCP (last visited Mar. 7, 2023) (defining "customary" to mean "defined by *long-continued* practices") (emphasis added); *see also Custom*, BLACK'S LAW DICTIONARY (11th ed. 2019) (defining custom to mean "[a] practice that by its *common* adoption and *long, unvarying* habit has come to have the force of law") (emphasis added).

42. *McKeehan*, 57 A.2d at 909–10 (affirming the trial court's rejection of expert testimony regarding the reasonable worth of medical services based on a lump-sum valuation rather than an itemized approach).

43. *Id.* at 910; *see also* Commonwealth v. DeJesus, 860 A.2d 102, 107 (Pa. 2004) ("The weight of the evidence is exclusively for the [jury], which is free to believe all, part, or none of the evidence, and to assess the credibility of the witnesses.").

44. Eagle v. Snyder, 604 A.2d 253 (Pa. Super. Ct. 1992).

In *Eagle*, the Pennsylvania Superior Court held the trial court failed to give proper weight to the testimony of an expert witness who opined on the reasonableness of medical fees charged in York County "based on what was customary and reasonable . . . in up to 90 areas throughout the country."[45] Citing *Husik* for the proposition courts value a provider's services based on what they are "ordinarily worth in the community," the court stated this rule must be reinterpreted in light of the sea change in medical practice during the intervening sixty-three years.[46]

The court stressed two "modern realities" absent in *Husik* that mandated a revised reasonableness standard.[47] First, the emergence of private and government medical insurance, which regulate medical costs through standardized procedure codes and other uniform billing practices.[48] Second, the court noted patients routinely "seek treatment outside the community or area in which they live or receive insurance coverage."[49] The "dispersal" of medical services, as well as the fact that "pricing and reimbursement may occur at different locations," required a "broader pricing concept . . . moving toward a more uniform regional or national standard."[50]

In light of these changes, as well as the fact the procedure at issue was performed by only one medical practice in York County, the court held it improper for the trial court to apply the narrower *Husik* standard when calculating the reasonable value of the medical services.[51] In fact, limiting the relevant community to just York County would result in "monopolistic forces" determining the value of the services rendered.[52] Rather, the trial court should have determined reasonable value by looking to "Cumberland, Dauphin[,] and Lancaster counties[,] which border upon York and have similar demographics and economic bases."[53] The court noted the situation would have been markedly different had the procedure been performed in Philadelphia or Allegheny counties as "there would, without question, be a broad enough base for determining a community standard without looking outside the community."[54] But *Eagle* involved a "monopolist price" set by two doctors who had "no peers in the immediate community."[55] Thus, the court held that *Husik* "cannot be so narrowly

45. *Id.* at 254.
46. *Id.*
47. *Id.*
48. *Id.*
49. *Id.*
50. *Id.*
51. *Id.*
52. *Id.*
53. *Id.* at 255.
54. *Id.*
55. *Id.*

construed to a county locale and such a limited practice in light of today's standards."[56] The court vacated the trial court's judgment and remanded with instructions that the trial court give proper weight to the expert testimony it ignored.[57]

Interestingly, the court acknowledged *Pfeiffer*, but found it inapposite. In the court's view, *Pfeiffer* was a relic of a bygone era with "little application to this case or modern practice."[58] The court explained:

> Because of the advent of medical insurance and Medicare . . . , and also due to the different perception of doctors concerning the practice of medicine, the rationale employed in *Pfeiffer* is far more difficult to sustain . . . . The court [in *Pfeiffer*] justified the doctor's fee on humanitarian considerations after [noting that half his services were performed for free]. No facts were developed in this case to show compensatory adjustments were made in the fees claimed to account for charity by [the plaintiffs].[59]

Thus, sans evidence of charity, the providers in *Eagle* where not entitled to the same pricing leeway as the doctor in *Pfeiffer*.

Yet the *Eagle* decision was not unanimous. Judge Beck authored a dissent that argued the majority warped existing law based on its "generalized perceptions concerning the practice of medicine in this country, for which there is no evidentiary support."[60] Beginning its analysis with *Husik*, the dissent observed that the implied promise to pay the reasonable value of medical services hinged upon "the value of the services on the professional market. The relevant market is deemed to be the market for such services in the *community*."[61] The dissent defined "community" to mean "the geographic area where the services are performed, since . . . [n]either [party] is presumed to have intended that he or she would either pay or receive what might be paid or received at some unspecified distant location."[62] However, the dissent acknowledged the validity of the majority's concerns over monopolies, stating:

> [W]here there are several doctors performing the same service in the immediate geographic area, the reasonableness of the fees will be evaluated on the basis of fees charged in the immediate geographic area. Usually, where only one physician or one group of related

56. *Id.* at 255–56.
57. *Id.* at 256.
58. *Id.*
59. *Id.* (citation omitted).
60. *Id.* at 256 (Beck, J., dissenting).
61. *Id.* at 260 (Beck, J., dissenting).
62. *Id.* (Beck, J., dissenting); *see also id.* at 262 (Beck, J., dissenting) ("It must be recalled that the contract in which we are implying a price term [is] . . . between the[] doctors and . . . the patient. It is the understanding, intent[,] and expectation of these parties that is pertinent to our determination of reasonableness . . . .").

> physicians perform the service in the immediate geographic area, the reasonableness of the fee charged may be evaluated on the basis of a broader geographic area.[63]

In short, *Husik*'s community-based reasonableness standard "assumes a competitive market,"[64] and the geographic limits of that market vary from case to case. The dissent also noted the abuse of discretion standard of review and the flexible charging practices of *Pfeiffer*.[65]

Applying the above principles to the case at bar, the dissent concluded that the trial court did not err in rejecting the expert testimony concerning the reasonable value of the medical services.[66] The expert formed his opinion on "nationwide" data and made no attempt to discover what a doctor in the same place as the procedure would have charged for the same services to someone in the same position as the patient.[67] In the dissent's view, the expert's methodology undermined his opinion because the community-based standard "requires that reasonableness be determined by reference to what is usual and customary *in the community, and not on the basis of what is usual and customary in the nation as a whole*."[68]

The dissent was unmoved by the majority's claim that a revolution in the practice of medicine required the court to modernize *Husik*'s community-based reasonableness standard.[69] The record lacked any evidence to support the majority's contentions, and, even if such evidence existed, *Husik* was binding precedent the panel could neither ignore nor overrule.[70] Seeing as the trial court properly applied the *Husik* standard, and the providers established prima facie evidence of the reasonableness of their fees, the dissent would have affirmed the trial court's judgment.[71]

Despite Judge Beck's well-reasoned dissent, no petition for allowance of appeal was filed in *Eagle*. The case was the most current articulation of the reasonable value of medical services for the next eleven years, but an unjust enrichment case would unseat it.

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63. *Id.* at 260 (Beck, J., dissenting).
64. *Id.* (Beck, J., dissenting).
65. *Id.* (Beck, J., dissenting).
66. *Id.* (Beck, J., dissenting).
67. *Id.* (Beck, J., dissenting).
68. *Id.* (Beck, J., dissenting) (emphasis added).
69. *Id.* at 261 (Beck, J., dissenting).
70. *Id.* (Beck, J., dissenting); *see also, e.g.*, Commonwealth v. Bucknor, 657 A.2d 1005, 1007 n.1 (Pa. Super. Ct. 1995) (noting three-judge panels are bound by the decisions of the en banc court).
71. *Eagle*, 604 A.2d at 261 (Beck, J., dissenting).

IV. QUANTUM MERUIT BY WAY OF UNJUST ENRICHMENT

As stated earlier, Pennsylvania courts have a proud tradition of using quantum meruit and unjust enrichment interchangeably.[72] They may not mean to, but they do. By and large, the mix-up is harmless and sometimes even necessary as in *Temple University Hospital, Inc. v. Healthcare Management. Alternatives, Inc.*[73] In *Temple*, the trial court held Temple University Hospital ("Hospital") was entitled to recover under an unjust enrichment claim and awarded the Hospital restitution as the difference between what it was paid and its published rates for services.[74] On appeal, the Pennsylvania Superior Court concluded the Hospital's published rates exceeded the community standard for the price of hospital care.[75] As a result, the court held the defendant, an out-of-network managed care company for Medicaid recipients, was not liable for paying the full amount charged by the Hospital, only a reasonable amount.[76]

In the absence of a contract, the *Temple* court reasoned an insurer is not obliged to pay the Hospital's published rates for services because hardly anyone pays those rates.[77] Relying on the quantum meruit principles articulated in *Eagle*, the court held that "the defendant should pay what the services are ordinarily worth in the community. Services are worth what people ordinarily *pay* for them."[78] The court went on to state:

> While the Hospital's published rates for services may be the same or less than rates at other Philadelphia hospitals, the more important question is what healthcare providers *actually receive* for those services . . . . [T]he Hospital rarely recovers its published rates. Therefore, those rates cannot be considered the value of the benefit conferred because that is not what people in the community ordinarily pay for medical services.[79]

Indeed, "ninety-four percent of the time, [the Hospital] received eighty percent or *less* of its full published charges," and it received its full charges "in only one to three percent of its cases."[80] Consequently, the

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72. *See supra* Part I.

73. Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc. 832 A.2d 501 (Pa. Super. Ct. 2003).

74. *Id.* at 506.

75. *Id.* at 508.

76. *Id.* at 509.

77. *Id.* at 508; *see also* Nation, *Obscene Contracts*, *supra* note 24, at 118 ("Hospitals devote significant time and effort to establishing and updating their charge master . . . . However, hospitals establish these charges with the clear expectation that they will receive only a portion of these so-called 'full charges.'") (footnote omitted).

78. *Temple*, 832 A.2d at 508 (citation omitted) (emphasis added).

79. *Id.*

80. *Id.* The *Temple* court also noted the Hospital's "full published charges in 1994 were approximately 172% of its actual costs, while in 1995 and 1996, the published rates

court held a "windfall" would result if the Hospital were awarded restitution pursuant to its published rates.[81] Instead, the Hospital should have been awarded the difference between what the defendant paid and the Hospital's "average collection rate."[82] Accordingly, the court vacated the trial court's judgment and remanded for further proceedings so the Hospital could establish the reasonable value of its services.[83] The Hospital petitioned for allowance of appeal, which the Pennsylvania Supreme Court denied.[84]

The *Temple* court may have muddied the conceptual waters by invoking contract principles like quantum meruit that were discussed in *Eagle*, but this is understandable. As noted earlier in this Article, unjust enrichment dictates comparison with just enrichment, and the difference is the measure of the restitution owed.[85] The *Temple* court needed some way to measure the gain retained by the defendant insurer, but the Hospital's published rates were an unreliable benchmark. So, the *Temple* court resorted to quantum meruit to ascertain a just comparison figure and, thus, bootstrapped its way into the realm of unjust enrichment. Armed with a reasonable comparison figure supplied by contract law, the *Temple* court ultimately decided the case, in accordance with the doctrine of unjust enrichment, by requiring restitution to be awarded as the difference between the amount paid by the insurer and the reasonable value for the same services (i.e., the average reimbursement rate).[86]

However, *Temple* was not a unanimous decision. Judge Tamilia, author of the *Eagle* majority, penned the dissent in *Temple*. Relying on *Husik*'s community-based reasonableness standard, the dissent argued that the Hospital was free to demand payment in accordance with its published rates.

> The evidence supports the conclusion [the] Hospital's published rate is the same or less than other Philadelphia hospitals. Moreover, there was no credible evidence presented to suggest the published rate was unconscionable, and there is no language in the applicable federal or state legislation that prohibits [the] Hospital, under the circumstances of this case, from charging its published rates. In the absence of a

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were approximately 300% of its actual costs," and "private payors typically paid 121% of the cost of hospital services in 1994, 119% in 1995, and 112% in 1996." *Id.* at 509; *see also id.* at 509 (stating that the Hospital had "twelve contracts with commercial insurance companies and that *none* of those contracts provided for payment at published rates").

81. *Id.* at 508.

82. *Id.* at 509.

83. *Id.* at 510.

84. Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc., 847 A.2d 1288 (Pa. 2004) (per curiam).

85. *See supra* Part II.

86. *Temple*, 832 A.2d at 509.

> contract . . . , [the] Hospital had no recourse but to rely upon its published charge[s].[87]

Further, echoing the *Pfeiffer* court, the dissent cautioned that hospital viability depends on charging more of those who can pay more to subsidize discounted care.

> When hospitals are required to enter into non-compensatory or inadequately compensated treatment, their ability to service the community will sooner or later be eliminated through bankruptcy, merger with a more productive cost effective institution, or reliance on a non-contractual modality, as here, where [the] Hospital's established published rates are based on the community standard and are equivalent to rates equal or lower than the rates charged by other Philadelphia hospitals.[88]

Lastly, the dissent insinuated the majority's approach amounted to judicial price-setting, which was inconsistent with *Husik*'s community-based reasonableness standard.[89] Thus, the dissent would have affirmed the trial court's judgment.[90]

While Judge Tamilia's dissent has merit, there is an inescapable irony to it. In the dissent, one sees the author of the *Eagle* majority, which refashioned *Husik*'s community-based reasonableness standard and overruled the trial court's discretion, compose a lament for *Husik* and call for judicial restraint on the part of appellate courts. It only took eleven years, but Judge Tamilia finally came around to the position Judge Beck advocated in her *Eagle* dissent.

V. THE *TEMPLE* STANDARD RESOLVES THE QUANTUM MERUIT CONFUSION

The development of Pennsylvania law regarding the quantum meruit or reasonable value of medical services leaves one with the abiding impression of a zigzag rather than a straight line. The various precedents are a kludge of competing rules and policy rationales. One senses the law searching for a way to root reasonable value in empirical data—rather than anecdotes or illusory figures—while abstaining from unnecessary meddling in the free market. In essence, the quantifier trying to quantify the seemingly unquantifiable.

87. *Id.* at 516 (Tamilia, J., dissenting).
88. *Id.* (Tamilia, J., dissenting).
89. *See id.* (Tamilia, J., dissenting) ("What constitutes a 'reasonable value,' . . . while a matter of much debate among medical care providers and commercial health insuring organizations, is a matter not to be decided by this [c]ourt.").
90. *Id.* at 517 (Tamilia, J., dissenting).

According to *Husik*, wherever an implied-in-fact contract for medical services fails to specify price, the law supplies a promise to pay the reasonable value of those services.[91] Arguably saying the same thing three different ways, *Husik* held the reasonable value of medical services is either "what they are rated at on the professional market," their "customary price," or "what they are ordinarily worth in the community."[92] This community-based reasonableness standard operates on a "county locale" basis[93] and "assumes a competitive market" in that limited area.[94]

But where, as in *Eagle*, a monopoly on medical services exists, price comparison in a competitive market is untenable. Reasonable value, like unjust enrichment, cannot be measured in a vacuum. If the self-serving testimony of the provider who operates a monopoly is the only evidence of the medical services' worth, then the probative value of that testimony is weak.[95] Under those circumstances, the communal boundaries must expand so the factfinder may appraise the medical services "on the basis of a broader geographic area" utilizing multiple providers.[96] To prevent an apples-and-oranges situation, this broader area should reflect "similar demographics and economic bases" as the area where the monopoly operates.[97]

Notwithstanding Judge Beck's dissent to the contrary, *Eagle*'s regional-based reasonableness standard appears cabined by the facts of the case. Indeed, the *Eagle* court reaffirmed the central holding of *Husik* when it stated metropolitan areas like Philadelphia would provide a "broad enough base" for determining the reasonable value of medical services.[98] This broad base refers implicitly to other medical providers because *Eagle* involved a "monopolist price" set by doctors with "no peers in the immediate community."[99] Still, Judge Beck's *Eagle* dissent astutely notes that application of a regional-based standard means the relevant "community" is virtually unbounded; parties end up contracting to "pay or receive what might be paid or received at some unspecified distant

91. Husik v. Lever, 95 Pa. Super. 258, 260 (1929) (en banc).

92. *Id.*

93. Eagle v. Snyder, 604 A.2d 253, 256 (Pa. Super. Ct. 1992); *accord Local Custom*, BLACK'S LAW DICTIONARY (11th ed. 2019) (defining a "local custom" as one that "prevails in some defined locality only, such as a city or county, and constitutes a source of law for that place only").

94. *Eagle*, 604 A.2d at 260 (Beck, J., dissenting); *accord Husik*, 95 Pa. Super. at 260.

95. *See id.* at 255.

96. *Id.* at 260 (Beck, J., dissenting); *see also id.* at 255–56 (stating *Husik*'s community-based reasonableness standard cannot be "narrowly construed to a county locale" when monopolistic pricing is present).

97. *Id.* at 255.

98. *Id.*; *see also* Husik v. Lever, 95 Pa. Super. 258, 260 (1929) (en banc) ("Professional services are worth . . . what they are ordinarily worth *in the community*." (emphasis added)).

99. *Eagle*, 604 A.2d at 255.

location."[100] Depending on the shortage of providers in a certain area or the rarity of the procedure, Pennsylvania providers could find the reasonable value of their services measured against providers in far-flung areas serving totally different populations.[101] This expansive meaning of the word community eviscerates *Husik*'s reasonableness standard.

Furthermore, whether one applies the *Husik* or *Eagle* standard, proof of the reasonable value of medical services will likely take the form of expert opinions—i.e., other providers who can speak to what the medical services are ordinarily worth in the "community" (however defined).[102] Expert opinion will differ because the amount charged for a given service varies widely, not only from place to place and doctor to doctor, but from patient to patient attended by the same doctor in the same place for the same service. The absence of fixed prices stems, in part, from (1) each patient's unique financial circumstances, and (2) providers' freedom to tailor their charges to fit those circumstances.[103] Those who can pay more, pay more, and those who can pay less, pay less. Thus, few medical situations have an identical twin vis-à-vis price.[104]

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100. *Id.* at 260 (Beck, J., dissenting).

101. *Contra Community*, BLACK'S LAW DICTIONARY (11th ed. 2019) (defining "community" to mean "[a] neighborhood, vicinity, or locality"); *Community*, DICTIONARY.COM, https://perma.cc/5JSS-LYJH (last visited Jan. 31, 2023) (defining "community" to mean "a social group of any size whose members reside in a specific locality").

102. *Eagle*, 604 A.2d at 255.

103. Pfeiffer v. Dyer, 145 A. 284, 285 (Pa. 1929).

104. *See id.* (noting the lack of "any fixed standard of pecuniary value" for medical services). *Pfeiffer*'s observations persist into the twenty-first century, where providers still regularly charge patients exorbitant rates for services; whether they collect these charges in full is another matter. Considering many patients have health insurance, and many insurers have contracts with providers governing the price of services, the agreement between the provider and the insurer supersedes the contractual obligation, including price to be paid, between patient and provider. Nation, *Healthcare*, *supra* note 12, at 100. Moreover, these in-network insurers often pay steeply discounted reimbursement rates, which are a percentage of the provider's "full" charge. Nation, *Obscene Contracts*, *supra* note 24, at 119. This arrangement compels providers to increase their published rates to maximize revenue. *See, e.g.*, George A. Nation III, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients*, 65 BAYLOR L. REV. 425, 454–55 (2013) [hereinafter *Determining*]. Hence, there is still no single, fixed standard of pecuniary value for medical services. This reimbursement scheme disproportionately affects uninsured and out-of-network patients due to not having a superseding contract between insurer and provider that governs the price of care. *See id.* at 431. This unfairness may be a necessary evil because the fear is that lowering the published rates would diminish revenues, jeopardizing providers' bottom lines. *Cf., e.g.*, *Determining*, *supra* at 454–55. Such analysis backs into Judge Tamilia's concerns about inadequate compensation spawning medical deserts through hospital closures. *See* Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc., 832 A.2d 501, 516 (Pa. Super. Ct. 2003) (Tamilia, J., dissenting).

But these transparent rationalizations are unpersuasive. Healthcare markets do not operate like other markets. Save for purely elective procedures, most medical services are of a life-and-death nature. Few patients are free to choose whether or when they enter the

Yet the practice of adjusting the charge of a medical service based on a patient's ability to pay is in tension with the basic premise of quantum meruit. On one hand, *Husik* held determining the reasonable value of medical services looks to the "professional market," "customary price," and what services are "ordinarily worth in the community."[105] On the other hand, *Pfeiffer* approved of the custom whereby "doctors of repute" regularly adjust the proper charge for services.[106] A sliding scale approach to pricing medical services erodes the whole idea of a market-based, customary, or ordinary charge. Such a regime means every charge is sui generis. Standardization disappears under a mound of exceptions, and fixing the reasonable value of medical services with any precision is nigh-on impossible, even with the aid of expert testimony. Factfinders, unversed in matters of medical practice and billing, may substitute their own judgment regarding the valuation of medical services for the expert opinion of providers familiar with the services' customary price.[107] In non-jury proceedings, this judgment is subject to the most deferential standard of review: abuse of discretion.[108]

The above overview should make clear that what starts as an objective inquiry into the reasonable value of medical services in a community ultimately turns on the ad hoc pricing of providers and the unguided discretion of the factfinder. Part of this conundrum is unavoidable. As with any reasonableness standard, the outcome is always case-specific and fact-intensive. But unlike, say, the reasonableness of attorney's fees paid from a trust or an estate, which must be assessed against several cognizable factors,[109] efforts to calculate the reasonable value of medical services reveal the lack of any hard-and-fast rules.[110] As

market for medical services. *See, e.g.*, *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 607–08 (2012) (Ginsburg, J., concurring in part and dissenting in part). This reality creates a bargaining power asymmetry in favor of providers, ensuring a steady demand for medical services regardless of price. *See, e.g.*, Nation, *Obscene Contracts*, *supra* note 24, at 116. As Chief Justice Roberts observed: "'Your money or your life' is a coercive proposition . . . ." *Sebelius*, 567 U.S. at 582 n.12 (plurality opinion). In sum, providers could charge less for services and remain viable, but perverse incentives continue to increase the cost of healthcare. *See, e.g.*, *Determining*, *supra* at 454–55.

105. Husik v. Lever, 95 Pa. Super. 258, 260 (1929) (en banc).

106. *Pfeiffer*, 145 A. at 285.

107. *In re* McKeehan's Estate, 57 A.2d 907, 910 (Pa. 1948).

108. *Id.*; *see also* Commonwealth v. Norton, 201 A.3d 112, 120 (Pa. 2019) (defining the abuse of discretion standard).

109. *See, e.g.*, *In re* LaRocca Estate, 246 A.2d 337, 339 (Pa. 1968) (outlining multiple factors courts should consider when assessing reasonable attorney's fees).

110. In the spirit of the *LaRocca* factors, *see id.*, some elements factfinders could consider when attempting to fix the reasonable value of medical services are, among others, (1) the experience of the doctor, (2) the nature of the services, (3) the ease or difficulty of the case, (4) the results obtained, (5) what is considered by the attending physician and other doctors an ordinary or reasonable charge for the services, and (6) what patients

if to underscore this point, there are surprisingly few Pennsylvania precedents applying what little guidance exists. *Eagle* is the most recent contract case regarding the quantum meruit of medical services, and it was decided over thirty years ago.

Then along came *Temple* like a brick through the window. *Temple* ostensibly relied on *Eagle* to assess the reasonable value of the Hospital's medical services,[111] but *Temple* is a break from, not a conduit for, *Eagle*'s regional-based reasonableness standard. In fact, *Temple*'s reasonableness standard turns on a definition of "community" even narrower than *Husik*'s "county locale" approach. Rather than compare the Hospital's charges against those of its Philadelphia-based competitors as in *Husik* or hospitals in the Greater Philadelphia area as in *Eagle*, *Temple* rejected the entire idea of geography and peer comparison. For the *Temple* court, the relevant community was the Hospital's pool of in-network patients, and the reasonable value of medical services was what the Hospital received from insurers for in-network patient care.[112] This amount was the customary price for services—not the amount billed to in-network patients, and neither the amount billed nor received from uninsured or out-of-network patients.[113] The *Temple* court reframed the inquiry, shifting the focus from providers to insureds—or, more precisely, their third-party payors. Instead of comparing what different providers in roughly the same area *charged* for the same service, the *Temple* court examined what one hospital, in insolation from its immediate competitors, *received* for treating in-network patients.[114]

Whether intentional or not, *Temple* fashioned a new reasonableness standard out of whole cloth, but the court's decision was likely motivated by the same "monopolistic" pricing concerns present in *Eagle*. Just as *Eagle* involved a lack of price competition due to the absence of other providers in the area that performed the same procedure, the Hospital's published rates were also unfettered by competitive market forces. As the *Temple* court remarked, the Hospital's published rates for services were "unilaterally set" and bore "no relation to the amount typically paid."[115]

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typically pay for the services. However, a similar list of factors is conspicuously missing from Pennsylvania law.

111. Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc., 832 A.2d 501, 508 (Pa. Super. Ct. 2003) (citing Eagle v. Snyder, 604 A.2d 253 (Pa. Super. Ct. 1992)).

112. *Id.* at 510 (holding the reasonable value of medical services is the amount paid by the "community"—*i.e.*, the "average charge" for services based on "contracts with governmental agencies and insurance companies").

113. *See id.* ("Reasonable value is what someone normally receives for a given service in the ordinary course of its business from the community that it serves.").

114. *See id.* at 508 ("Services are worth what people ordinarily pay for them.").

115. *Id.* at 510.

By focusing on the amount *received* rather than the amount *billed*, the *Temple* court bypassed the three-card Monte that is a provider's charges.[116] *Temple*'s approach presents only a tiny window onto the healthcare sector's byzantine reimbursement system,[117] but it nonetheless offers an accurate picture of medical services' value based on nothing more than the provider's own conduct.[118] Moreover, the average reimbursement rate is not especially difficult to verify or monitor because providers track this information and reimbursement rates are regularly renegotiated thereby updating the base rate.[119] Given its tangible connection to real market forces, the *Temple* reasonableness standard adds much needed teeth to the *Eagle* court's dicta regarding the sway exerted by private and government insurers on healthcare costs.[120] The *Temple* standard holds up a mirror to the provider. If the provider hates what it sees, the provider should direct that critical gaze inward.

Of the cases discussed in this Article, the *Temple* court's approach cuts through the precedential knot of *Husik* and *Eagle*—even if the court's reasonable value formula (i.e., the average reimbursement rate) is a tad conservative.[121] However, *Temple* was an unjust enrichment case, and its

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116. *See, e.g.*, Nation, *Obscene Contracts*, *supra* note 24, at 103–04 ("The amount [a] hospital is willing to accept for its . . . services varies depending on who the patient is, or more precisely, on the identity of the payor.").

117. *See id.* at 117 (stating provider pricing policies are "the product of a maze of confusing and contradictory regulations resulting from the third-party reimbursement system").

118. *See id.* at 135–36 (explaining how "courts are generally ill equipped to determine a reasonable value or fair price" for services, but courts are "not required to set the price because the hospitals have, in fact, already set a reasonable price"—*i.e.*, "the average amount the hospital actually receives and accepts as full payment" from insurers).

119. Nation, *Determining*, *supra* note 104, at 464.

120. *See* Eagle v. Snyder, 604 A.2d 253, 254 (Pa. Super. Ct. 1992).

121. While all providers maintain a charge master list for their services, providers often discount these rates to varying degrees for third-party payors. *See, e.g.*, Nation, *Obscene Contracts*, *supra* note 24, at 102 n.12. Several factors incentivize providers to accept discounted rates, including "an increased volume of business through access to patients who are insured by the insurance company, assurance of quick and full payment of discounted charges from the insurance company, as well as marketing and advertising benefits that result from being listed as 'in-network' by the insurance company." George A. Nation III, *Healthcare and the Balance-Billing Problem: The Solution is the Common Law of Contracts and Strengthening the Free Market for Healthcare*, 61 VILL. L. REV. 153, 188 (2016) [hereinafter *Balance-Billing*]. Consequently, scholars have argued the reasonable value of medical services should be the average reimbursement rate plus an additional percentage that accounts for the value of the benefits providers receive from insurers in exchange for discounted rates. *See, e.g.*, Nation, *Determining*, *supra* note 104, at 461–65. Nothing in this Article should be construed as disapproving of this upward adjustment to the base average reimbursement rate. When it comes to the reasonable value of medical services, the *Temple* standard should be viewed as a floor rather than a ceiling. If a provider believes the reasonable value of its services is higher than what its average reimbursement rate would suggest, then the provider should be free to present corroborating evidence of that higher value.

reasonableness standard strays far from the traditional community- and regional-based standards of *Husik* and *Eagle*, respectively. Thus, *Temple*'s precedential value in a strict quantum meruit action is suspect.

But, if not the *Temple* standard, then what is the proper method for calculating the reasonable value of medical services? This thorny question steers the discussion back to *Husik* and *Eagle* as well as the laissez-faire economics of *Pfeiffer*. Best to avoid all that. *Temple* discards the vagaries of peer comparison and amorphous geography and replaces both with a quantifiable, bright-line rule: the reasonable value of medical services is equal to what the provider receives for those services, which is the average rate collected for treating in-network patients.[122]

Temple's more granular approach simultaneously shrinks the relevant "community" to a more manageable size compared to *Husik* and *Eagle* and manages to reinforce *Pfeiffer*'s free-market philosophy. Something as idiosyncratic as the price of medical services is not a one-size-fits-all phenomenon, and the law should recognize this fact by granting providers sufficient flexibility to set their own prices.[123] But flexibility has its limits, and those limits are self-imposed. By focusing on the average bargained-for rate a provider receives, a court may safely assume the provider's acceptance is a tacit admission of the rate's reasonableness. Would the provider have contracted to accept this amount otherwise? Further, because *Temple*'s reasonableness standard represents the average arm's-length transactions of multiple market participants, the standard circumvents concerns about judicial price-setting like those hinted at in Judge Tamilia's *Temple* dissent.[124] In fact, the *Temple* standard guarantees "[n]o individual market participant, provider or insurer, may control the base" price.[125] Lastly, *Temple*'s reasonableness standard is the one followed in Pennsylvania's sister jurisdictions, including Arizona,[126] California,[127] and Texas.[128] Strange bedfellows to be sure, but adherence to any other reasonableness standard for medical services places Pennsylvania at odds with this large, and growing, body of persuasive authority.

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122. Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc., 832 A.2d 501, 510 (Pa. Super. Ct. 2003).

123. *See* Pfeiffer v. Dyer, 145 A. 284, 285 (Pa. 1929).

124. *See Temple*, 832 A.2d at 516 (Tamilia, J., dissenting).

125. Nation, *Balance-Billing*, *supra* note 121, at 189.

126. *See* Canyon Ambulatory Surgery Ctr. v. SCF Ariz., 239 P.3d 733, 742–43 (Ariz. Ct. App. 2010).

127. *See* Child.'s Hosp. Cent. Cal. v. Blue Cross of Cal., 172 Cal. Rptr. 3d 861, 873 (Ct. App. 2014).

128. *See* In re N. Cypress Med. Ctr. Operating Co., 559 S.W.3d 128, 133 (Tex. 2018).

VI. CONCLUSION

Any lawsuit in Pennsylvania that involves the reasonable value of medical services implicates the fuzzy law of quantum meruit. But, thanks to *Temple*, there exists a workable standard for determining reasonable value (i.e., the average reimbursement rate) that bypasses the unprincipled map-drawing and peer comparisons of *Husik* and *Eagle*. *Temple*'s status as an unjust enrichment case should not preclude application of its reasonableness standard to traditional quantum meruit actions, but this remains an open question. Should litigants decide to test the broader applicability of *Temple*'s reasonableness standard, that case stands a good chance of making its way before the Pennsylvania Supreme Court. Over the years, the Pennsylvania Superior Court has created a mishmash of precedents regarding the reasonable value of medical services that the high court has yet to untangle.[129] Further, everyone needs healthcare eventually, and an unsettled question of law that affects the cost of healthcare in Pennsylvania impacts the lives of thirteen million residents[130]—clearly a question of substantial public importance requiring prompt and definitive resolution.[131] Therefore, any dispute over the reasonable value of medical services has the potential both to regulate the price of healthcare and clarify an especially ill-defined area of Pennsylvania law. The quintessential win-win.

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129. *See* PA. R. APP. P. 1114(b)(1), (3).
130. *See* U.S. CENSUS BUREAU, *Pennsylvania: 2020 Census*, https://perma.cc/C7UP-YDB9 (last visited Mar. 3, 2023).
131. *See* PA. R. APP. P. 1114(b)(4).